



## Missouri Pharmacy Program – Preferred Drug List



### Multiple Sclerosis Agents

*Effective 02/01/2006*

*Revised 10/02/2014*

#### Preferred Agents

- Avonex® Kit/Administration Pack
- Copaxone® 20mg
- Betaseron®
- Rebif®
- Rebif Rebidose®
- **Extavia®**
- **Gilenya®**

#### Non-Preferred Agents

- Aubagio®
- Tecfidera®
- **Copaxone® 40mg**

<u>Approval Criteria</u>	<u>Denial Criteria</u>
Failure to achieve desired therapeutic outcomes with trial on <b>3 preferred</b> agents <ul style="list-style-type: none"><li>○ Documented trial period for preferred agents</li><li>○ Documented ADE/ADR to preferred agents</li></ul>	Lack of adequate trial on required preferred agents
Documented compliance on current therapy regimen	Therapy will be denied if no approval criteria are met
<b>Gilenya Therapy Available</b> <ul style="list-style-type: none"><li>○ <b>After documented trial on one injectable biologic agent</b></li></ul>	Drug Prior Authorization Hotline: (800) 392-8030